
	State of Colorado **Department of Human Services** **Department of Health Care Policy and Financing**
	Name of Applicant Date Application Received by County or MA site Signature of Person Who Received the Application

Please mark each program you are applying for.

	Cash Assistance Programs		**Medical Assistance Programs**
❑	Aid to the Blind (State AB)	❑	Family Medical Assistance (FM)/Child Health Plan *Plus* (CHP+)
❑	Aid to the Needy Disabled (State AND)	❑	Adult Medical Assistance (AM) (Aged, Blind and Disabled)
❑	Colorado Supplement to SSI	❑	Long-Term Care Medical Assistance (LTC) (Nursing Facility or Home and Community Based Services)
❑	Colorado Works (TANF)	❑	Medicare Savings Program (MSP) (Medicare Part B Recipient)
❑	Food Assistance	❑	Emergency Medical Assistance (Non-Citizens)
❑	Home Care Allowance (HCA)		**Other Assistance Programs**
❑	Old Age Pension (OAP) Financial (If you check this box, also check Adult Medical Assistance)	❑	Low Income Subsidy (LIS) (Medicare Part D Recipient) Before you apply for this program, please contact **1-800-MEDICARE** to find out if you are already enrolled

Language Information

English: If you need help completing this application, please contact your local county department of social services.

Spanish: Si usted necesita ayuda a completar esta aplicación, contacta por favor su departamento local de condado de servicios sociales.

Russian: Если Вы нуждаетесь в помощи, заканчивая это заявление, пожалуйста свяжитесь с вашим местным отделом социального обеспечения графства.

Arabic: اتّصل بإن أنت تحتاج مساعدة يتمّ هذا تطبيق, رجاء كمحلّية إقليم قسم من خدمات اجتماعيّة.

Farsi: اگرشمااحتیاج بداریدکمک کنیدلطفاکامل کردن این درخواست ، “

قسمت استان محلیتان رادخدمات اجتماعی تماس بگیرد

Vietnamese: Chương trình chưa dịch được câu này. Câu của bạn sẽ được chuyển đến những người sử dụng khác dưới dạng bài tập. Nếu bạn dịch được ngay câu này, hãy nhấn nút.

State of Colorado
Department of Human Services
Department of Health Care Policy and Financing

Information You Need To Know

Take this section with you.

You may use this application to apply for any of the programs listed below at the county Department of Social Services where you live.

Anyone has the right to apply for help at any time.

Do I have to be a U.S. citizen to apply for assistance?

No, you do not have to be a U.S. citizen to apply for assistance. Please do not let the fear of the U.S. Citizenship and Immigration Services (U.S.C.I.S.) stop you from seeking benefits for your family. Receiving health coverage and food Assistance for your eligible children will not stop you from gaining lawful permanent residence or U.S. citizenship, but receiving other types of aid may.

You do not have to provide a Social Security Number, nor will we contact U.S.C.I.S., for anyone not seeking benefits.

How do I apply for assistance?

To apply you must complete an application and turn it in at the county department where you live.

- You may mail, fax or drop it off in person.
- You may be required to attend an interview.
- You may have family, friends or the county help you complete this form.

Available Services/accommodations

Handicap Accessible

Vision Impaired

ASL

TDDY

Language Interpreters

What will I need to provide? **Sending copies or bringing the following items with your application may help you get your benefits quicker. (You may not need all these items to apply.) Tell your county worker if you cannot get these (he or she will help):**

	Your identification, such as picture ID or drivers license;
	Social Security numbers or proof of application for everyone requesting benefits. If you state on the application that you have a Social Security Number, you will need to provide proof;
	Proof of current wages or income for your household, such as pay stubs, award letter, employer letter, Social Security, child support;
	Proof of resources (assets), such as checking, savings, vehicles, CD's, IRA's, stocks, life insurance, burial policies;
	Proof of status in this country such as Visa, Legal Permanent Resident Card, Passport, or Employment Authorization Card for everyone you are applying for;
	If someone is pregnant, proof of when the baby is due (letter or statement from a health care provider or doctor);
	Information on any parent(s) not living in the home of the children you are applying for;
	Health insurance card or policy; and/or
	Proof of expenses such as day care, rent, mortgage, utilities, child support or medical costs.

The Programs We Offer -Food Assistance

Food Assistance is a program to assist with the cost of food. Anyone may apply. If you are eligible, you must receive your benefits within certain time frames (see page 4 under "Processing Time"). If you need food right away and you meet certain guidelines, you will be entitled to expedited Food Assistance.

For Food Assistance, you must provide proof of your alien status if you are not a United States citizen. Citizenship is only verified if it is questionable. If you are not applying but are part of the household, no alien documentation or Social Security numbers are required.

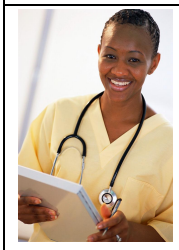
You can immediately file an application with the applicant's name, address and signature of a responsible household member or household's authorized representative, by completing and submitting the first page of the application. The remainder of the application can be completed at home and may be brought in person, faxed, or mailed back to the Food Assistance office. Benefits will be paid from the filing date, which is the date the Food Assistance office receives your application. The filing date is different if the household is in an institution and applying for Food Assistance and SSI at the same time. In this case, the filing date is the date of release from the institution. The Food Assistance household must have an interview, which may be completed by phone.

You may use an authorized representative to apply for Food Assistance and another, separate authorized representative to use your EBT card.

Title VI of the Civil Rights Act of 1964 allows the State to ask for racial/ethnic information. You do not have to state your racial/ethnic information and not giving the information will not affect the application. Your county worker will complete this information if it is not answered. You have a right to request a fair hearing orally or in writing if you disagree with any action taken on the case.

Cash Assistance

- **Colorado Supplement to SSI (Supplemental Security Income)** This program is for persons who are receiving SSI but not receiving the full SSI amount.
- **Colorado Works/TANF (Temporary Assistance for Needy Families)** Through the Colorado Works Program, counties provide family stabilization assistance and other supportive services to enable eligible low-income families to find and retain employment and to provide for their children. Assistance and services provided may include child care, housing and transportation, cash payments, counseling for those experiencing domestic violence, mental health or substance abuse problems, and services aimed to reduce the incidences of out-of-wedlock births and encourage the formation and maintenance of two parent families.
- **Old Age Pension (OAP)** This is a cash assistance program for low-income persons, ages 60 or over, and may include medical assistance.
- **State Aid to the Blind (AB)** This program is for persons, ages birth–59, who are blind. This is a cash assistance program and does not include medical benefits.
- **State Aid to the Needy Disabled (AND)** This program is for persons, ages 18–59, who are totally disabled for at least 6-months. This is a cash assistance program and does not include medical benefits.
- **Home Care Allowance (HCA)** This is a cash assistance program for individuals that need assistance in daily living.
- **Adult Foster Care (AFC)** This is a cash assistance program for some individuals that need protective oversight on a 24-hour basis.



Medical Assistance

- **Family Medical Assistance (FM)/Child Health Plan *Plus* (CHP+)** For children 18 and under, families and pregnant women. Immediate, temporary coverage may be available for pregnant women and children through the Presumptive Eligibility Program.
- **Adult Medical Assistance (AM)** For persons who are 65 or older or for those who are applying based upon disability or blindness.
- **Long-Term Care Medical Assistance (LTC)** For persons needing help to pay for services received in their homes or a medical facility for more than 30 days. A medical and functional assessment is required.
- **Medicare Savings Program (MSP)** For persons needing help to pay for some of their Medicare Part B costs, such as premiums, deductibles and co-insurance.
- **Emergency Medical Assistance** For certain non-citizens who need help with an emergency medical expense and meet program eligibility criteria.

Other Assistance

- **Low Income Subsidy (LIS)** For persons needing help to pay for some of their Medicare Part D costs, such as premiums, deductibles and co-insurance.

Processing Time

From the date the agency receives your completed application, they must act within:

- 7 days for Expedited Food Assistance, 30 days for Food Assistance;
- 45 days for Medical Assistance Programs, Colorado Works/TANF, Colorado Supplement
- 60 days for State Aid to the Needy Disabled (AND) and Aid to the Blind (AB);
- 90 days for Medicaid applications awaiting a disability determination.

Proof of Lawful Presence in the United States

This is required for Financial Programs only. It is not required for Medicaid, CHP+ or Food Assistance. You must provide verification of your lawful presence in the United States for applicants 18 years and older for certain public benefits, with:

- A valid Colorado Driver's license or Colorado Identification card; or
- U.S. Military Card or Military Dependent's Identification Card; or
- United States Merchant Mariner Card; or
- Native American Tribal Document.

If you do not have the documents listed, you may contact your local county office for other acceptable documents. You must sign the Affidavit of Proof of Lawful Presence in the United States located in the application.

Proof of Citizenship and Identity

This is required for Medicaid and CHP+

U.S. citizens who are applying for Medicaid or CHP+ must provide proof of citizenship and identity. Some U.S. citizens are exempt from providing proof of citizenship and identity. Some of these exemptions include newborns born to mothers receiving Medicaid or CHP+ at the time of birth, SSI & SSDI eligible clients, current Medicare recipients, and children in foster care.

There are four documents that prove **both** citizenship and identity:

- A U.S. Passport
- A Certificate of Citizenship
- A Certificate of Naturalization,
- An Indian Tribal Document

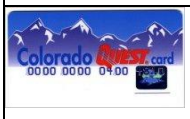
If an applicant does not have one of these documents, they must provide:

- One document that proves U.S. citizenship, **AND**
- One document that proves identity.

Some examples of proof of citizenship are a U.S. birth certificate, a U.S. National ID card (form I-197 or I-179), final adoption decree, or an official military record showing a U.S. place of birth. Some examples of proof of identity are a driver's license, a state ID card with a picture, a school ID with a picture, or verified school, nursery or childcare records for children under 16.
If an applicant does not have any of these documents, there are many more options. For more information call customer service: **• Within Denver metro area: 303-866-3513 • Outside Denver metro area: 800-221-3943**

Copies of the original citizenship and identity documents (or certified originals) will be accepted **only** after originals have been viewed and verified by a site approved by the State of Colorado. You can take your original documents to be verified at your county department of human/social services' office or to an Application Assistance Site. **Notarized copies will not be accepted.**

A list of Presumptive Eligibility and Application Assistance Sites can be found at the Department of Health Care Policy and Financing's Web site: Colorado.gov/hcpf.

	FOR FOOD ASSISTANCE: You must provide proof of your alien status if you are not a United States citizen. Aliens and alien household members who are not eligible to participate in the food stamp program will not be required to provide alien documentation or social security numbers.
OTHER ASSISTANCE	**To apply for the following programs, you will need a separate application.** **Colorado Child Care Assistance Program (CCCAP)** The Colorado Child Care Assistance Program provides financial assistance to low-income families who are working, searching for employment or in training. Families that are enrolled in the Colorado Works Program and need childcare services to support their efforts toward self-sufficiency are also eligible. The CCCAP is administered through individual county departments of social services. **Low Income Energy Assistance Program (LEAP)** LEAP may assist with part of your winter heating costs. You may apply from November 1st through April 30th. Applications are available at the county office, by calling 1-866-HEAT HELP (1-866-432-8435), or you may visit our web site at cdhs.state.co.us/leap/. **Low-Income Telephone Assistance Program (LITAP)** LITAP may assist with part of your telephone costs. Contact 1-800-782-0721, or you may visit our web site at cdhs.state.co.us/leap/. **Child Support Enforcement** For persons needing help establishing paternity, or establishing and enforcing child support and medical support. A $20 application fee is required for persons who do not receive cash assistance. For additional information about the programs listed, visit the following web sites: cdhs.state.co.us or colorado.gov/hcpf.
	Domestic violence information and services are also available to you. If you ever feel you are in immediate danger call 911. If you would like to receive information regarding safety and services in Colorado, call the Colorado Coalition Against Domestic Violence at 303-831-9632 or toll free at 1-888-778-7091. You may also find the location of services near you by going to colorado.gov/cdhs/dvp. The National Domestic Violence Hotline at 1−800−799−SAFE (7233) or TTY 1−800−787−3224 or go to ndvh.org can also provide information. If you are a survivor of domestic violence, sexual assault, or stalking the Address Confidentiality Program (ACP) can provide you with a legal substitute address to use instead of your real address for use with state and local government agencies. You can find out more about the ACP at acp.colorado.gov/ If you are in need or receive either of these services please inform your county worker.
	**How to receive your benefits:** **Colorado's Electronic Benefits Transfer (EBT) QUEST Card.** Food stamp and cash benefits are issued on an EBT card. You can receive a card at your county department or have an EBT card mailed to you. You will need to select your Personal Identification Number (PIN) to access the benefits once they are put on the card. To contact QUEST customer service you may call toll free at 1-888-328-2656.
	**Medical Card** If you are found eligible for Medicaid, you will be mailed a Medical Identification Card. Present this card each and every time you receive medical services. If your card is lost or stolen, please contact your county department of human/social services. A separate medical card will be sent to those who qualify for the CHP+ program.
	If you are found eligible for cash assistance, you may request to have your cash benefits directly deposited into your bank account. Ask your county worker for details.

Local County Offices: phone, director and address

Adams County (303) 287-8831 Donald M. Cassata, Director 7190 Colorado Blvd. Commerce City 80022	**Alamosa County** (719) 589-2581 Larry Henderson, Director P.O. Box 1310 (mail) 610 State Street (physical) Alamosa 81101	**Arapahoe County** (303) 636-1130 Cheryl Ternes, Director 14980 E. Alameda Drive Aurora, CO 80012	**Archuleta County** (970) 264-2182 Erlinda Gonzales, Director P.O. Box 240 (mail) 551 Hotsprings Blvd Pagosa Springs 81147	**Baca County** (719) 523-4131 Ruth Wallace-Porter, Director 772 Colorado Street Ste.1 Springfield 81073
Bent County (719) 456-2620 x 108 William G. Schultz, Director 215 2nd Street (physical and mail) Las Animas 81054	**Boulder County** (303) 441-1000 Paula McKey, Director 3400 Broadway Boulder 80304	**Broomfield County** (720) 887-2222 Debbie Oldenettel, Director 6 Garden Center Broomfield 80020	**Chaffee County** (719) 530-2500 Philip Maes , Director 448 E. First Street Room 166 Salida, CO 81201	**Cheyenne County** (719) 767-5629 Tonya Lemley, Director P.O. Box 146 (mail) 51 South 1st (physical) Cheyenne Wells 80810
Clear Creek County (303) 679-2365 Cindy Dicken, Director P.O. Box 2000 (mail) Georgetown 80444	**Conejos County** (719) 376-5455 Maria Garcia, Director P.O. Box 68 (mail) 12989 County Road G.6, Conejos, Colorado 81129	**Costilla County** (719) 672-4131 Tommy Vigil, Interim Director P.O. Box 249 (mail) 233 Main St, Suite A (physical) San Luis 81152	**Crowley County** (719) 267-5248 x 248 Tonia Burnett, Director 631 Main Ste 100 (physical) Ordway 81063	**Custer County** (719) 783-2371 Laura Lockhart, Director P.O. Box 929 (mail) 205 South 6th Street (physical) Westcliffe 81252
Delta County (970) 874-2030 Chuck Lemoine, Director Courthouse Annex, 560 Dodge Delta 81416	**Denver County** (720) 944-3666 Patricia Wilson-Pheanious Director 1200 Federal Blvd. Denver 80204-3221	**Dolores County** (970) 564-4105 Dennis A. Story, Director P.O. Box 485 (mail) 420 North Main, Courthouse (physical) Dove Creek 81324	**Douglas County** (303) 688-4825 Barbara Drake Director 4400 Castleton Court Castle Rock 80109-7804	**Eagle County** (970) 328-8840 Rachel Oys Director P.O. Box 660 (mail) 551 Broadway Street (physical) Eagle 81631
Elbert County (303) 621-3149 Catherine Robinson Director P.O. Box 544 (mail) 214 Comanche St. (physical) Kiowa, Co. 80117	**El Paso County** (719) 444-5532 Richard Bengtsson Director P.O. Box 2692 (mail) Colorado Springs 80901 105 North Spruce (physical) Colorado Springs 80905	**Fremont County** (719) 275-2318 Steven A. Clifton Director 172 Justice Center Road Canon City 81212	**Garfield County** (970) 945-9191 x3037(Glenwood Springs) (970) 625-5282 (Rifle) Lynn Renick, Director 195 West 14th Street Rifle, CO 81650 Glenwood Springs - 108 8th Street Suite 300 Glenwood Springs 81601	**Gilpin County** (303) 582-5444 Betty Donovan Director 2960 Dory Hill Rd., Suite 100 Black Hawk 80422
Grand County (970) 725-3331 Glen Chambers, Director P.O. box 204 (mail) 620 Hemlock (physical) Hot Sulphur Springs 80451	**Gunnison County** (970) 641-3244 ext. 1 Renee Brown Director 225 N. Pine Street, Suite A Gunnison 81230	**Hinsdale County** (970) 641-3244 ext. 1 Renee Brown Director 225 N. Pine St, Suite A Gunnison 81230	**Huerfano County** (719) 738-2810 ext 18 Sheila Hudson Director 121 W 6th Street Walsenburg, CO 81089	**Jackson County** (970) 723-4750 Glen Chambers Director P.O. Box 338 350 McKinley Street Walden 80480

Jefferson County (303) 271-1388 Lynn Johnson , Director 900 Jefferson County Parkway Golden 80401-6010	**Kiowa County** (719) 438-5541 Dennis Pearson, Director P.O. Box 187 (mail) Courthouse, 1307 Maine Street (physical) Eads 81036	**Kit Carson** (719) 346-8732 Kindra Mulch R.N., Administrator 252 S. 14th St. P.O. Box 70 Burlington 80807	**Lake County** (719) 486-2088 Jeri M. Lee, Director P.O. Box 884 (mail) 112 W. 5th Street (physical) Leadville 80461	**La Plata County** (970) 382-6150 Lezlie Mayer, Director 1060 E. Second Avenue Durango 81301
Larimer County (970) 498-6300 Ginny Riley, Director 1501 Blue Spruce Dr. Fort Collins 80524-2000	**Las Animas County** (719) 846-2276 Catherine Salazar Director 204 S. Chestnut Street Trinidad 81082	**Lincoln County** (719) 743-2404 x141 Colette Barksdale, Director P.O. Box 37 (mail) Courthouse, 103 3rd Ave. (physical) Hugo 80821	**Logan County** (970) 522-2194 x228 Fredrick J. Crawford, Director P.O. Box 1746 (mail) 508 South 10th Ave., Suite 2 (physical) Sterling 80751	**Mesa County** (970) 248-2703 Len Stewart, Director P.O. Box 20000-5035 (mail) 510 29-1/2 Road (physical) Grand Junction 81502-5035
Mineral County (719) 657-3381 James Berg, Director P.O. Box 40 (mail) 1015 6th Street (physical) Del Norte 81132	**Moffat County** (970) 824-8282 Marie Peer, Director 595 Breeze Street Craig 81625	**Montezuma County** (970) 564-4105 Dennis A. Story, Director 109 W. Main, Room 203 Cortez 81321	**Montrose County** (970) 252-5000 Peg Mewes, Director 1845 South Townsend Montrose 81401	**Morgan County** (970) 542-3530 Steve Romero , Director P.O. Box 220 (mail) 800 East Beaver Avenue (physical) Fort Morgan 80701
Otero County (719) 383-3100 Donna Rohde, Director P.O. Box 494 (mail) Courthouse, 3rd & Colorado (physical) La Junta 81050	**Ouray County** (970) 626-2299 Allan Gerstle, Director P.O. Box 530 Ridgway, Co. 81432 177 Sherman St. Unit 104 (physical) Ridgway, Co. 81432	**Park County** (303) 816-5930 Mary Baydarian, Director PO Box 1193 Bailey, 80421	**Phillips County** 970-854-2280 Judy McFadden, Director 127 East Denver, Suite A Holyoke, CO 80734	**Pitkin County** 970-920-5209 Nan Sundeen Director 0405 Castle Creek Road Suite 8 Aspen, CO 81611
Prowers County (719) 336-7486 Linda Fairbairn, Director P.O. Box 1157 (mail) 1001 South Main (physical) Lamar 81052	**Pueblo County** (719) 583-6160 Jose Mondragon, Director 212 W. 12th Street Pueblo 81003	**Rio Blanco County** (970) 878-9640 Bonnie Ruckman, Director 345 Market Street, Meeker 81641-3421	**Rio Grande County** (719) 657-3381 James Berg, Director P.O. Box 40 (mail) 1015 6th Street (physical) Del Norte 81132	**Routt County** (970) 879-1540 Vickie Clark, Director P.O. Box 772790 (mail) 135 6th Street (physical) Steamboat Springs 80477
Saguache County (719) 655-2537 Jeannie Norris , Director P.O. Box 215 (mail) 605 Christy Ave. (physical) Saguache 81149	**San Juan County** (970) 387-5326 Lezlie Mayer , Director 1557 Greene Street, P.O. Box 376 Silverton 81433	**San Miguel County** (970) 728-4411 Allan Gerstle, Director P.O. Box 96 (mail) 333 West Colorado Ave. (physical) Telluride 81435	**Sedgwick County** (970) 474-3397, ext.13 Lisa Ault, Director P.O. Box 27 (mail) 118 West 3rd (physical) Julesburg 80737	**Summit County** (970) 668-9161 Joanne Sprouse DSS Manager P.O. Box 869 (mail) 360 Peak 1 Dr. Stuite 230 (physical) Frisco 80443
Teller County (719) 687-3335 Kim Mauthe, Director P.O. Box 9033 (mail) 740 Highway 24 (physical) Woodland Park 80866-9033	**Washington County** (970) 345-2238 Rick Agan, Director 126 West 5th (physical) Send mail to: PO Box 395 Akron 80720-0395	**Weld County** (970) 352-1551 Judy Griego, Director P.O. Box A (mail) 315 North 11th Ave. (physical) Greeley 80632	**Yuma County** (970) 332-4877 x306 David K. Henson, Director 340 South Birch Street Wray 80758-1814	

State of Colorado
Department of Human Services
Department of Health Care Policy and Financing

Application for Assistance

Important Information for Food Assistance (formerly called Food Stamps) applicants: Please complete and sign page 1 of this application to begin the process to apply for benefits. The information requested on the additional pages is needed to determine your eligibility.

Important Information for Long-Term Care applicants: If you are applying for Medicaid Long-Term Care and need to secure your application date for Medicaid billing, please copy pages 1 through 5 and sign page 21. Submit the completed pages to your local Human Services office. You must submit the entire application within 10 business days from the date you submitted the pages. If applicable, please identify your Long-Term Care Institution name here: _____

Household Information

Tell us about you

Last Name	First Name	Middle Initial	Maiden or other name you have used

Sex: ❑Male Female❑ (Answer to this question is not required by Food Assistance.)

Date of Birth (mm-dd-yyyy)	Place of Birth (City, State, Country)
Social Security Number (SSN) ❑ Check if you do not have a SSN | | | | - | | | - | | | | |	Phone number	Message Number (or another number to contact you or where message can be left)

Home Address (Street, PO Box, etc.)	Mailing Address (if different than home address)
City State ZIP Code	City State ZIP Code
Signature	Date

Available Services/accommodations

Handicap Accessible

Vision Impaired

ASL

TDDY

Language Interpreters

Household Information

Tell us more about you

Race/National Origin/Ethnicity (Optional, check all that apply):
❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American
❑ Hispanic or Latino ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other

Student? ❑Yes No ❑
If yes, please complete Last Grade Completed _____ Name of school _____

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑ *If yes, please complete:* ➢ Due Date (mm-dd-yyyy) _____ Number of Babies Expected _____

Marital Status: ❑ Married ❑ Never Married ❑ Divorced ❑ Widowed ❑ Separated

1. **What is your primary language?** Spoken: _____Written: _____
2. **Are you a Colorado resident?** ❑Yes No❑
3. **Are you or anyone in your household receiving benefits from another State, or have any of you received benefits from another state?** ❑Yes No❑ *If yes, please complete*:

   What benefits are you receiving? _____ Date last received _____ What state/county? _____
4. **Are you receiving any benefits from another Colorado county?** ❑Yes No❑
5. **Are you homeless?** ❑Yes No❑

Nondiscrimination Statement

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Assistance Act and USDA policy, discrimination is also prohibited on the basis of marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public program. (Not all prohibited bases apply to all programs.) If you think you have been discriminated against for any of these reasons, you can file a complaint with the County Client Civil Rights Contact Person. At any time, you may also file a complaint of discrimination with one of the following Federal agencies, without fear of retaliation:

For Financial Assistance issues, contact:
US Department of Health and Human Services (HHS)
Director, Office for Civil Rights (OCR)
Room 506-F, 200 Independence Ave. S.W.
Washington, D.C. 20201
(202) 619-0403 (*voice*) or (202) 619- 3257 (*TDD*)

For Food Assistance issues, contact:
US Department of Agriculture (USDA)
Director, Office for Civil Rights
1400 Independence Ave., SW
Washington DC, 20250-9410
(800) 795-3272 (*voice*)

** Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape) should contact USDA's TARGET Center at 202-720-2600 (voice or TDD).* We will make reasonable efforts to meet your special needs if you have a qualifying disability under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Contact your county worker if you have special needs and want to request a reasonable accommodation under the ADA.

Expedited Services for Food Assistance. Your household may qualify for Expedited Service and receive food Assistance within 7 days. If you would like to apply for expedited Food Assistance, complete this box. You must meet one of the following criteria:

- ❑ Your gross monthly income is less than $150 and liquid resources are $100 or less; or
- ❑ Your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or
- ❑ Your household is a migrant or seasonal farm worker household with little or no income and resources

Give us the information below, so your eligibility for expedited service can be determined:

How many people live with you? _____

Total money expected this month before deductions _____

Total cash, money in checking/savings accounts, CDs _____

Total utilities for this month _____

Total rent or mortgage for this month _____

If you qualify for Expedited Food Assistance: You are to receive benefits within seven days of your application. If you are denied Expedited Food Assistance and you do not agree with the denial, you may request an informal conference at your Food Assistance office. This conference is to be held within two days of your request unless you ask for a later date.

6. Have you, or any member of your household, been convicted of fraudulently receiving duplicate Food Assistance benefits in any State after September 22, 1996? ❑Yes No❑

7. Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, or violating a condition of parole or probation? ❑Yes No❑ *If yes, who?* _____

8. Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled drug substance (felony drug conviction) or for a crime committed while under the influence of a controlled drug substance after August 22, 1996? ❑Yes No❑ *If yes, who*?_____

9. Have you or any member of your household been convicted of buying or selling Food Assistance benefits over $500 after September 22, 1996? ❑Yes No❑

10. Have you or any member of your household been convicted of trading Food Assistance benefits for guns, ammunitions, or explosives after September 22, 1996? ❑Yes No❑

11. Have you or any member of your household been convicted of trading Food Assistance benefits for drugs after September 22, 1996? ❑Yes No❑

12. Have you, or any member of your household, applying for assistance been convicted of Welfare Fraud? ❑ Yes No❑ *If yes, who*?_____

Household Information

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Household Information

Tell us about everyone in your household who is applying for assistance

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Name (last, first, middle initial) | Relationship to You | SSN ❑Check if you do not have a SSN

Date of Birth (mm-dd-yyyy) | Place of Birth (City, State, Country)

Student? ❑Yes No❑ *If yes, please complete:* Last Grade Completed | Name of school

Race/National Origin/Ethnicity (Optional, check all that apply):

❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑White ❑Other

Answers to the following questions are not required by Food Assistance:

Pregnant? ❑Yes No❑
If yes, please complete ➢ Due Date (mm-dd-yyyy) | Number of Babies Expected

Marital Status: ❑Married ❑Never Married ❑Divorced ❑Widowed ❑Separated | Sex: ❑Male Female❑

Household Information **Tell us about anyone else who lives with you (even if they are not applying for assistance). You must list everyone who lives with you even if they are not applying. If you have already listed them in the previous section you do not need to list them here.**

Name	Relationship to You	Date of Birth	Sex (Answer to this question is not required for Food Assistance.)	Do they usually buy food, prepare food, and eat with everyone in the house?
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑
			❑ Male Female❑	❑ Yes No❑

Expenses **Tell us about the expenses of your household. This section will collect information about your shelter expenses. Some programs will consider these costs when determining how much your benefits should be.**

13. What is your current living arrangement? *Check all boxes that apply to your situation.*

❑ Own/Buying a home ❑ Renting ❑ Living with relatives ❑ Living on an Indian reservation
❑ Living with friends ❑ Living in subsidized housing ❑ Migrant/seasonal farm worker
❑ No permanent home ❑ Living in a group home ❑ Staying at a shelter

14. Are you applying for benefits for anyone in a Medical Facility? *(For Example: Hospital, Nursing Home, Mental Health Institution)* ❑Yes No❑ *If yes, please complete::*

Name	Name of Facility	Medical Facility Address	Date Entered
1.			
2.			
3.			

15. Does anyone outside of the household help pay any shelter costs? ❑Yes No❑ *If yes, please complete:*

Who helps pay: _____

How much do they pay per month? **$** _____

Expenses Tell us about the expenses of your household.

I/We understand that my household may receive higher Food Assistance benefits if I/we report and verify: child/adult daycare, court ordered child support paid, housing costs, and medical expenses for elderly or disabled members. I/We understand that failure to report and verify the above expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses.

16. Do you provide support to an individual not living in your household? ❑Yes No❑
If yes, do you also claim them on your Federal Income Tax? ❑Yes No❑

17. Are you asked to pay, or are you billed, for rent or a mortgage? ❑Yes No❑ *If yes, please complete:*

	Amount Paid	Amount Billed	How Often	Landlord/Mortgage Name/Address/Phone
Rent	$	$		
Mortgage	$	$		
2nd Mortgage	$	$		
3rd Mortgage	$	$		

18. Are your homeowner taxes, insurance, and homeowners' association (HOA) fees billed separately from the above house payment? ❑Yes No❑ *If yes, please complete:*

	Amount Billed	Amount Paid	How Often	Name/Address Where Payment Is Sent
HOA	$	$		
Insurance	$	$		
Taxes	$	$		

19. Do you, or anyone in your household, pay legally obligated child or spousal support to someone outside of your household? ❑Yes No❑ *If yes, please complete*:

Child Support or Spousal Maintenance Paid							
Name(s) of persons receiving support	**Person paying support**	**Legally obligated amount**	**Amount Actually Paid**	**Date of Last Payment**	**How Often Paid**	**County/State of Court Order**	**Amount of Arrearages**
1.							
2.							

Expenses Tell us about the expenses of your household.

20. Are you billed for any of the following: heating, cooling, water, trash, sewage or phone expenses? ❑Yes No❑ *If yes, please complete*:

	Amount Billed	Amount Paid	How Often	Name and Address where Payment is Sent
Heating	$	$		
Air Conditioning	$	$		
Electricity	$	$		
Water	$	$		
Trash	$	$		
Sewer	$	$		
Phone/Cell phone	$	$		

21. Is anyone in your household billed for child care? ❑Yes No❑ *If yes, please complete*:

Name of child Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Are you receiving help with these costs?
1.					❑Yes No❑
2.					❑Yes No❑

22. Are you, or anyone in your household, disabled? ❑Yes No❑ *If yes, please complete*:

Name of the Person with the Disability	Currently receiving treatment?
1.	❑Yes No❑
2.	❑Yes No❑
3.	❑Yes No❑

23. Has a medical provider told you, or anyone in your household, to cut back or limit activities? ❑Yes No❑ *If yes, please complete*:

Name of Person with Limitations _____ Limitations _____

Expenses Tell us about the expenses of your household.

24 Are you, or is anyone in your household, billed for care of an adult or disabled person?
❑Yes No❑ *If yes, please complete*:

Name of Person Receiving Care	Care Facility/Provider Name and Address	Amount Billed	Amount Paid	How Often Paid	Receiving help with these costs?
1.					❑Yes No❑
2.					❑Yes No❑
3.					❑Yes No❑

25. Do you, or anyone in your household, have an injury? ❑Yes No❑ *If yes, please complete*:

Name of Injured Person _____ Date of Injury _____

25a. Was this injury work related? ❑Yes No❑

25b. Have you filed a Workers' Compensation claim for this injury? ❑Yes No❑

25c. Do you, or does anyone in your household, have a lawsuit or claim for any injuries? ❑Yes No❑ *If yes, which household member and filing date of claim (if known)?*

Name _____ Date _____

26. Do you have an attorney? ❑Yes No❑ *If yes, please complete*:

Attorney Name _____ Address _____

Phone/ FAX _____ City _____ State ZIP Code _____

27. Does anyone outside the household help pay medical costs? ❑Yes No❑

28. Do you, or anyone in your household, have Medicare? ❑Yes No❑ *If yes, please complete*:

Name of Person Receiving Medicare	Which Part of Medicare?	Effective Date	Claim Number
1.	Part A ❑ B ❑ C ❑ D ❑		
2.	Part A ❑ B ❑ C ❑ D ❑		
3.	Part A ❑ B ❑ C ❑ D ❑		
4.	Part A ❑ B ❑ C ❑ D ❑		

Expenses Tell us about the expenses of your household.

Medicaid and CHP+

29. Does anyone who is applying have health insurance now? ❑Yes No❑

If yes, please complete: *(Include a copy of the front/back of the insurance card).*

Name(s) of person(s) covered**:** _____

Policyholder's name: _____ Last name _____ First Name _____ Middle Initial

_____ Policy /Group number _____ Name and address of insurance company

29a. Has anyone in the household who is applying for CHP+ had health insurance through an employer's group in the last three (3) months? ❑Yes No❑ *If yes, please complete:*

_____ Why did the person lose this insurance? _____ When did this insurance end? (m/dd/yy)

_____ Policyholder's name _____ Phone number of insurance company _____ Name of employer's insurance company

_____ Name(s) of person(s) covered _____ Amount paid monthly _____ Amount employer paid each month

29b. Do you, or any member of your household, have access to group health insurance and would like help paying the monthly premiums? ❑Yes No❑

29c. Does either parent or legal guardian of this child work for a Colorado state government agency and have access to State health benefits? ❑Yes No❑ *(Some children of Colorado State agency employees may not be eligible for CHP+ due to federal law.)*

To receive health insurance by CHP+, you must choose an Health Maintenance Organization (HMO) for the child applying. You can find information about HMOs at colorado.gov/hcpf. Please list your HMO here:

30. Are you, or anyone in your household, paying medical expenses? (For Example: prescriptions, co-pays, health insurance premiums, insurance deductibles) ❑Yes No❑ *If yes, please complete*:

Name of Person with Expense	Name of Provider of the Service	Type of Medical Expense	Amount Paid	Date of Service	How Often
1.			$		
2.			$		
3.			$		
4.			$		
5.			$		

31. If you are under 21, do you or your children, need medical services? ❑Yes No❑ *If yes, please check the medical services you need?*

❑ Baby Shots ❑ Dental Check-Ups ❑ Eye Exams
❑ Hearing Tests ❑ Medical Check-Ups ❑ Pregnancy Care
❑ Sick Care/Medicine ❑ Supplemental Nutritional Program for Women, Infants and Children (WIC)

Expenses Tell us about the expenses of your household.

RETROACTIVE MEDICAID You can request Medicaid coverage for three months prior to this application date. If you wish to apply for Retroactive Medicaid, complete this box.

32. Did you, or anyone in your household, have medical expenses in the past three months?
❑Yes No❑ *If yes, please complete:*

Name of person with Medical Expenses in the Past 3 Months	Dates of Service

You will be required to provide verification of income and resources for these 3 months.

33. Do you, or anyone in your household, have health insurance/medical coverage other than Medicaid? ❑Yes No❑ *If yes, please complete*:

Name of Person Covered	Name of Policy Holder	Policy Number	Monthly Payment	Date of Coverage	Insurance Company Name, Address, and Phone Number

Not a U.S. Citizen? If you are not a U.S. citizen please complete this box.

34. Do you, your spouse, or parents, have *Work Quarters* in the United States? (A work quarter is equal to three months of work income recognized by Social Security). ❑Yes No❑

First Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	❑ Check if you do not have a SSN
Second Person's Name	Relationship to Applicant	SSN (optional)
Date of Entry (mm-dd-yyyy)	Alien Registration Number	❑ Check if you do not have a SSN

34a. Do you, or anyone in your household, have a sponsor? ❑Yes No❑ *If yes, please complete:*

First Sponsor's Name	First Sponsor's Complete Address		Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income $	Resources/ Assets $	Number in Sponsor's Family
Second Sponsor's Name	Second Sponsor's Complete Address		Relationship to Applicant
Sponsor's Phone Number	Gross Monthly Income $	Resources/ Assets $	Number in Sponsor's Family

Income This section will collect all income including wages or any other money received by you or anyone in your household.

35. Do you, or anyone in your household, have a job? ❑Yes No❑ *If yes, please complete:*

Name of Employed Person in your Household	Employer's Name, Address, and Phone Number	Date Started	Hourly Wage/ Tips	Gross Monthly Income	How Often Paid	What day is payday?
1.			$	$		
2.			$	$		
3.			$	$		
4.			$	$		

36. Did you, or anyone in your household, leave or lose a job in the past 60 days? ❑Yes No❑
If yes, please complete:

First person

Name of person who lost job	Reason for Leaving	Last Date Worked
$ Gross Amount of Last Paycheck	Date of Last Paycheck	Employer Name, Address, Phone:
Check if this was your final paycheck. ❑		

Second person

Name of person who lost job	Reason for Leaving	Last Date Worked
$ Gross Amount of Last Paycheck	Date of Last Paycheck	Employer Name, Address, Phone:
Check if this was your final paycheck. ❑		

36a. Did you, or anyone in your household, reduce the number of hours per week worked, in the past 60 days? ❑Yes No❑

Name of person whose hours were reduced	Reason for reduced hours	Number of hours worked before reduction	Number of current hours worked

Income Tell us about the income in your household.

37. Are you, or anyone in your household, self-employed? ❑Yes No❑ *If yes, please complete*: Are there other owners or partners? ❑Yes No❑

Name of Self-Employed Person

$		
Average Monthly Income	Number of Hours Worked Per Week	Business Name, Address, and Phone Number

You will be asked to provide proof of your business earnings and expenses.

38. Are you, or anyone in the household, on strike? ❑Yes No❑ *If yes, please complete*:

Name		Employer Name, Address, and Phone Number
$		
Gross Income Before Strike	Date Person Began Strike	Union Name, Address, and Phone Number

39. Have you, or anyone in the household, applied for Unemployment benefits? ❑Yes No❑ *If yes, please complete*:

Name of Person Who Applied for Unemployment	Date Applied for Unemployment
1.	
2.	
3.	

40. Does anyone pay you or any member of your household for meals, a room or both? ❑Yes No❑ *If yes, please complete*:

Name of Person Receiving Payment	Room Only ❑ Room and Meals ❑	$ Amount Received	How Often?
Name of Person Receiving Payment	Room Only ❑ Room and Meals ❑	$ Amount Received	How Often?

40a. Do you, or anyone in your household, have expenses for providing meals, a room or both? ❑Yes No❑ *If yes, you will be asked to provide proof of your business earnings/ expenses.*

Person Who Is Paying the Expense	Type of Expense	Amount of Expense	Hours Spent Providing Meals, a Room, or Both
1.		$	
2.		$	

Income Tell us about the income in your household.

41. Do you, or anyone in your household, attend college, technical school or trade school?
❑Yes No❑ *If yes, please complete*:

Name of Person Attending School	Enrollment Status	Expected Graduation Date	Name of School
1.	❑ Full-Time Part-Time ❑		
2.	❑ Full-Time Part-Time ❑		

42. Do you, or anyone in your household, receive student financial aid? ❑Yes No❑

Name of Student Receiving Financial Aid	Type of Expense (books, transportation, lab fees):	Type of Grants/Loans Received (Pell Grants, Stafford Loan, Perkins Loan, Work Study)
1.		
2.		

43. Have you, or anyone in your household, applied for Social Security Benefits or Supplemental Security Income (SSI)? ❑Yes No❑ *If yes, please complete*:

Name of Person(s) Who Applied	Date of Application	Status of Application (pending, approved, denied)
1.		
2.		
3.		
4.		

44. Have you, or anyone in your household received a lump sum payment? (For Example: a lawsuit settlement, insurance settlement, inheritance, proceeds from surrender of life insurance or annuity, or SSI or Social Security settlement) ❑Yes No❑ *If yes, please complete*:

Name of Person Who Received the Lump Sum	Type of Lump Sum	Amount Received	Date Received
1.		$	
2.		$	
3.		$	
4.		$	

Income Tell us about the income in your household.

45. Do you, or anyone in your household, receive any type of money other than income from work? ❑Yes No❑ *If yes, please complete*

Type of Income	Name of Person Receiving Income	Gross Amount Received	How Often Received?	Claim or Account Number
Alimony, Maintenance, Income from Ex-Spouse		$		
Annuity		$		
Cash Contributions/Gifts		$		
Child Support		$		
		$		
Dividends/Interest		$		
Income from Trust		$		
Insurance/Lawsuit Payments		$		
Loans		$		
Public Assistance (OAP, AND, AB, Colorado Works, TANF)		$		
Railroad Retirement Benefits		$		
Rental Income		$		
Retirement/Pension		$		
Social Security Benefits		$		
Unemployment Benefits		$		
Veterans Benefits		$		
Workers' Compensation		$		
Other Income: (Please describe)		$		
		$		

Resources Tell us about what you own, or are buying (For Example: vehicles, bank accounts, personal property or insurance for anyone in your household.) You are not required to complete the resource section if you are only applying for Family Medical Assistance and CHP+.

46. Do you or anyone in your household have the following? ❑Yes No❑ *If yes, please complete*:

Type	Owner	Account Number	Amount/ balance	Name/Address of institution	Jointly owned
Annuity			$		❑Yes No❑
Cash			$		❑Yes No❑
Certificate of Deposit (CD)			$		❑Yes No❑
Checking Account			$		❑Yes No❑
Savings Account			$		❑Yes No❑
College Fund/Educational Accounts			$		❑Yes No❑
Inheritance			$		❑Yes No❑
Investments, Mutual Funds			$		❑Yes No❑
PASS Account or Individual Development Account			$		❑Yes No❑
Proceeds from Sale of a Home or Other Assets			$		❑Yes No❑
Promissory Note(s) owed to you			$		❑Yes No❑
Retirement Account: IRA, Keogh, 401(k)			$		❑Yes No❑
Reverse Mortgage			$		❑Yes No❑
Safe Deposit Box			$		❑Yes No❑
Stocks/Bonds			$		❑Yes No❑
Trusts			$		❑Yes No❑
Other (Please describe)					❑Yes No❑

Resources Tell us about the resources in your household.

47. Do you, or anyone in your household, have a vehicle that you are buying, have registered, or own? (For Example: car, van, motorcycle, truck, RV, boat, trailer) ❑Yes No❑ *If yes, please complete*:

	First Vehicle	Second Vehicle	Third Vehicle	Fourth Vehicle	Fifth Vehicle
Name of Person on Title and Registration					
Name of Person with Vehicle					
Jointly Owned?	❑Yes No❑	❑Yes No❑	❑Yes No❑	❑Yes No❑	❑Yes No❑
Vehicle Make					
Vehicle Model					
Vehicle Year					
What Is Vehicle Used for (work, medical, school)					
Value	$	$	$	$	$
Amount Owed	$	$	$	$	$

48. Do you, or anyone in your household, have any life insurance? ❑Yes No❑ *If yes, please complete*:

	First Policy	Second Policy	Third Policy	Fourth Policy
Name of Insured Person				
Name of Insurance Company				
Insurance Company Address/phone				
Name of Policy Owner				
Policy Number				
Date Purchased				
Loan Against Policy	$	$	$	$
Type of Life Insurance (whole, term)				
Face Value	$	$	$	$
Cash Surrender Value	$	$	$	$

49. Do you, or anyone in your household, have a burial policy or any money set aside to be used for burial, cremation or other funeral expenses? ❑Yes No❑ *If yes, please complete*:

Name of Person the Money Is Being Held for	Amount Being held	Is it irrevocable?	Name, address, and phone number of Mortuary, Bank, Insurance Company or Person holding money
	$	❑Yes No❑	
	$	❑Yes No❑	

50. There may be help with funeral expenses for some recipients. If your family should need such help, what would you prefer? ❑ Cremation ❑ Burial ❑ No Preference

Resources Tell us about the resources in your household.

51. Did you, or anyone in your household, give away anything of value within the last 5 years or 3 months for Food Assistance? (For Example: land, home, money, buildings, cars, boats, cash) ❑Yes No❑ *If yes, please complete*:

Name of Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed
1.			$	$
2.			$	$
3.			$	$

52. Are you, or anyone in your household, buying or the owner of any real estate other than the property where you live? (For Example: rental property, Timeshare, warehouse, empty lot) ❑Yes No❑ *If yes, please complete for each piece of real estate:*

Name of First Owner(s) or Buyer(s)	Jointly Owned? ❑Yes No❑	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	$ Value	$ Amount Owed
Name of Second Owner(s) or Buyer(s)	Jointly Owned? ❑Yes No❑	Type of Real Estate
Address of Where Property is Located (Street, city, state, and country)	$ Value	$ Amount Owed

Veteran, or entitled to Veteran Benefits? Tell us about your veteran information in this box.

53. Have you, or anyone in your household, ever been in the military? ❑Yes No❑

53a. Are you the widow(er) or a survivor of anyone that has been in the military? ❑Yes No❑ *If Yes to either of the above questions, please complete:*

Veteran's name, address & phone number

Veteran's date of birth and place

If deceased, Veteran's date and place of death

Your Relationship to Veteran

Dates of Service

Branch of Service

Date of last VA benefit application or receipt of VA benefits

Serial Number

53b. If spouse of Veteran, what was the maiden name, date & place of marriage:

54. If we are in need of additional information regarding your application and are unable to contact you, whom may we contact?

Name of person, address and phone	Relationship to You

Rights, Responsibilities, and Penalties

For your protection, it is important to read the following carefully before you sign.

NOTICE TO MEDICAL ASSISTANCE CLIENTS – The Medical Assistance Estate Recovery Program: Under Federal law (Social Security Act, Title 19, Sec. 1917 [42 U.S.C 1396P]) and State law (25.5-4-302, C.R.S.), the Medical Assistance Estate Recovery Program authorizes the Department of Health Care Policy and Financing to recover all medical assistance benefits paid on behalf of Medicaid clients, including capitation payments, from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions about the Medical Assistance Estate Recovery you should contact your county worker and request "The Medical Assistance Estate Recovery Program" brochure.

I UNDERSTAND AND AGREE THAT:

It is a crime to lie on this application. Benefits will be denied if any information on this application is found not true or if requested information is left off the application. If any information that I provide is incorrect, my application may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information. I must tell the agency if there are changes in the information I give on this application within the time frames explained to me at the interview with the county worker. For Colorado Works (TANF), medical assistance programs and adult financial cases, I must inform the agency within 10 days of any changes to my case. I am allowing the agency to get records from financial institutions to show assets held for the person(s) named in this application. This includes banks, saving and loan companies, credit unions, insurance companies and other financial institutions. I am also allowing the agency to receive information from other persons or agencies to provide documentation or verify information in my application. I release these persons, agencies or institutions from all liability for supplying such information pertaining to myself or members of my household.

I will present proof of lawful presence in the United States (not required for Food Assistance), or alien registration documentation received from the United States Citizen and Immigration Service (USCIS), for every alien member in my household.

The agency will verify information with USCIS and that information received from USCIS may affect my eligibility and benefits. Federal law (Public Law 97-98) requires me to give the agency the SSN(s) and alien registration number(s) of persons who apply for public assistance. The agency will confirm and share information with other state, local and federal agencies. For Adult Financial Programs, sponsor information will be verified with USCIS and that the information received from USICS may affect sponsor repayment for my eligibility and benefits.

The agency will match information with the Social Security Administration, the Internal Revenue Service and the Colorado Department of Labor and Employment through the use of SSNs. The agency will verify information that may affect eligibility and payment. The agency will contact employers and they may release information to this agency. The agency will verify information regarding child support payments with child support enforcement agencies or the courts. The agency may provide information to law enforcement agencies.

Rights, Responsibilities, and Penalties (continued)

I UNDERSTAND AND AGREE THAT:

On approval of this application, I assign to the State all rights to payment for medical expenses and treatment. If I get Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. The State may collect from any insurance company or court settlement for medical bills that the State has paid. I will immediately notify the State of any claim or lawsuit that I have; and will cooperate with the State in collecting the medical bills that the State has paid.

If I get cash assistance under Colorado Works (TANF), I will give the agency all rights to current child support and spousal maintenance and unpaid support while I am receiving cash assistance. I know that I must give the agency rights to medical support to reimburse medical costs paid by Medicaid. I know I must give the agency all child support, medical support, and spousal maintenance paid directly to me while my children and I receive cash assistance under Colorado Works (TANF) and Medicaid. While my children and I receive cash assistance under Colorado Works (TANF) and Medicaid, the agency will try to collect current and overdue support. When we no longer receive cash assistance under Colorado Works (TANF) or Medicaid, the agency will continue to collect overdue support and medical support amounts that accrued while I received benefits. The current child support, spousal maintenance and medical support will be sent to me.

I must identify health insurance that is available to any person who is included in this application for Medicaid or medical assistance. I know that I may be required to enroll in an employer-based group health insurance if it is less expensive than Medicaid. In that case, Medicaid will pay the insurance cost.

My household will not be eligible for Food Assistance if I refuse to cooperate with any review of my case, including a quality control review. If my household gets benefits for which we are not eligible, we may be required to repay those benefits. Any past due claims may be collected by taking an income tax refund that my household may be entitled to.

A person found to have intentionally given false information cannot get Colorado Works (TANF) or Food Assistance for 12 months for the first offense, 24 months for the second offense, and permanently for the third offense. A court can also stop a person from getting Food Assistance for another eighteen months. This crime is subject to prosecution under other federal laws. Receiving duplicate benefits of Food Assistance or Colorado Works (TANF) by misrepresenting identity or residence will be a 10-year disqualification.

It is a crime to knowingly receive money or benefits for which I am not eligible. This crime is punishable by a fine of up to $250,000 or a jail term of up to 20 years, or both.

A person found guilty of using Food Assistance to illegally purchase controlled substances shall be disqualified for 2 years for a first offense and permanently for a second offense.

Individuals found by a Federal, State or local court to have used or received benefits in a transaction involving the sale of firearms, ammunition or explosives shall be permanently ineligible to participate in the Program upon the first occasion of such violation.

An individual convicted by a Federal, State or local court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to participate in the Program upon the first occasion of such violation.

Rights, Responsibilities, and Penalties (continued)

I UNDERSTAND AND AGREE THAT:

To receive Food Assistance, certain members of the household need to register for work. This means that certain members of the household must: 1) Report to the Employment First (work program) when the Food Assistance office schedules you for an appointment. 2) Comply with the instructions the Employment First (work program) gives you, including reporting for all scheduled appointments and following through on the written agreements you sign. 3) Provide information to the Food Assistance office or the Employment First (work program) about any jobs you get while you are on food Assistance. 4) Tell the Food Assistance office or Employment First (work program) if you are not able to work – you will be asked to provide verification; work any *Workfare Hours* you are assigned; go to job interviews arranged for you.

If you do not do what you are assigned to do, you may be disqualified from receiving Food Assistance benefits. If you are an adult between the ages of 18 and 49, with no children under the age of 18 in your Food Assistance household, you will only be able to get Food Assistance benefits for three months during the next three years unless: You work in a job 80 hours each month and report that information to Employment First (work program); or you work your assigned hours in your county's Employment First (work program), including *Workfare;* or The Employment First (work program), or you are determined to be physically or mentally unable to work, or the Food Assistance office tells you that you are exempt. As long as you do one of these activities each month, you will be able to receive Food Assistance benefits if you are otherwise eligible.

Your Signature

By signing this form, I certify that I have reviewed this application; I understand and agree to the Rights, Responsibilities and Penalties and under penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. I have received information on how to apply, what information is available, and what I may need to give the county to help me with getting benefits.

Signature of Applicant	Date (mm-dd-yyyy)
Applicant's Printed Name	Signature of person who helped complete application
Authorized Representative, Conservator, POA, or Guardian Signature	Date (mm-dd-yyyy)
Authorized Representative, Conservator, POA, or Guardian Printed Name	Guardian or person who helped complete application address/phone

This form is required for cash assistance. An Affidavit of Proof of Lawful Presence is required for each individual (age 18 or older) that is applying for cash benefits or for adults applying for cash benefits their children.

Affidavit of Proof of Lawful Presence in the United States

Please note, this affidavit is not required to apply for or receive Food Assistance and Medicaid programs that are subject to the Deficit Reduction Act of 2005. Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.
I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- ❑ I am a United States citizen; or
- ❑ I am a Legal Permanent Resident of the United States; or
- ❑ I am lawfully present in the United States pursuant to federal law

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature _____ Date _____

Affidavit of Proof of Lawful Presence in the United States

Please note, this affidavit is not required to apply for or receive Food Assistance and Medicaid programs that are subject to the Deficit Reduction Act of 2005. Every applicant in your household 18 years of age and older must sign an Affidavit of Proof of Lawful Presence in the United States.
I swear or affirm under penalty of perjury under the laws of the state of Colorado (Check one):

- ❑ I am a United States citizen; or
- ❑ I am a Legal Permanent Resident of the United States; or
- ❑ I am lawfully present in the United States pursuant to federal law

I understand this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature _____ Date _____

Child Support Information. This section must be completed if you have a noncustodial parent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you would like assistance with child support.

Are there any children in your household who have a parent(s) not living in the home? ❑Yes No❑ *If yes, please complete the following pages*:

Applicant's Full Name (last, first, middle initial; include maiden or any other names used) **SSN**

Phone Number **Message Number**

Home Address (street, PO Box, etc.) **Mailing Address** (if different than home address)

City **State** **ZIP Code** **City** **State** **ZIP Code**

IMPORTANT If cooperation could result in serious physical or emotional harm to you or the child(ren) due to the noncustodial parent becoming angry about paying child support or providing health insurance, you may apply for good cause. For good cause to be approved you must provide the county department with evidence within 20 days of your good cause claim. If you need more time you may request it. Examples of such evidence includes:

Court, criminal, child protective services, social services, psychological or law enforcement records that indicate that the alleged non-custodial parent might inflict physical or emotional harm on you or the children,

The child was born after forcible rape or incest. Evidence include medical or law enforcement records indicating incest or forcible rape occurred, or sworn statement from persons who have knowledge of the basis of claim,

The child is in the process of being adopted. Evidence includes court documents or a written statement from the public or private agency handling the adoption.

If it is decided, with your evidence that good cause is granted, your benefits will not be affected. If you do not have good cause you will receive notice from the county department to cooperate with the CSE unit, unless you appeal the decision.

If you have safety concerns for you or your children but still want the Child Support Enforcement unit to pursue the non-custodial parent for support, you may apply for the nondisclosure indicator (NDI). Once approved for NDI, your personal information will not be printed on child support documents filed with the court or displayed on documents sent to the other parent.

Do you wish to apply for NDI? ❑Yes No❑

Do you wish to request good cause? ❑Yes No❑

The Colorado Child Support Enforcement (CSE) Program assists you in getting child support for your children from the noncustodial parent (parent not living in your home). Also, the CSE unit can assist in collecting spousal maintenance. Such assistance includes locating the noncustodial parent, establishing paternity if needed and a child support order. The CSE unit also modifies child support orders when appropriate. As a condition of your Colorado Works (TANF) and/or Medicaid eligibility, *you must cooperate with the CSE unit*. Cooperating means giving information about the noncustodial parent to the CSE unit needed to proceed.

Failure to cooperate with the CSE unit could cause you to lose all or part of your Colorado Works (TANF) benefits or Medicaid for yourself. By cooperating, the noncustodial parent is held to their responsibility for your child or children.

You will receive a periodic notice of support payments collected by the CSE unit. When you are no longer receiving Colorado Works (TANF) or Medicaid, the CSE unit will continue to provide child support services. Collections for current child support, current spousal maintenance, and overdue support that is not assigned to the State will be sent to you. If you do not want CSE services, you must tell the CSE unit in writing. If you do, you will be responsible for enforcing the child support order on your own. Should the money collected be unfunded (a bad check, for example) you will be responsible for returning the money.

Child Support Information. **This section must be completed if you have a noncustodial parent from your home and you are applying for Colorado Works (TANF) or Adult Medicaid with SSI Children. You may complete this section if you voluntarily would like assistance with child support.**

This section collects needed information about your child(ren) and the parent(s) who are not included in your household but who may have a responsibility to children in your household. Please complete this section **only if you are applying for Colorado Works (TANF) and/or Adult Medicaid with SSI children** (recipients of other Medicaid types may apply for child support services).

	First Child	Second Child	Third Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

	Fourth Child	Fifth Child	Sixth Child
Full Legal Name			
Gender (M or F)			
Date of Birth			
SSN*			
State or County of Conception			
Who is listed as the father on the birth certificate?			

*SSNs are used by the CSE Program to locate individuals or to establish paternity and support obligations. Also, the SSN assists to modify and enforce support obligations and to distribute child support payments. However, if your child(ren) or the noncustodial parent's SSN is unknown, the CSE unit will not deny your request for assistance. The CSE unit may request more information at a later date, as needed, in their effort to get child and medical support for your family.

Legal Name of noncustodial Parent	1st Noncustodial Parent _____	2nd Noncustodial Parent _____	3rd Noncustodial Parent _____
Is there a court order for this noncustodial parent to pay Child Support?	❑Yes No❑ If yes, for which child? **1 2 3 4 5 6** PLEASE CIRCLE	❑Yes No❑ If yes, for which child? **1 2 3 4 5 6** PLEASE CIRCLE	❑Yes No❑ If yes, for which child? **1 2 3 4 5 6** PLEASE CIRCLE
If yes, enter the Court case number.			
If yes, enter the date of the order.			
If yes, enter court's city and state.			
If yes, enter the amount of child support order and how often to be paid (example: $200 a month).			
If yes, was medical support a part of the order?	❑Yes No❑	❑Yes No❑	❑Yes No❑
Last known address of noncustodial parent:			
Last known phone number:			
*SSN of noncustodial parent, date and place of birth (if neither is known, approximate age of noncustodial parent).	SSN DOB Or approximate age Place of birth	SSN DOB Or approximate age Place of birth	SSN DOB Or approximate age Place of birth
Is there any other information about the noncustodial parent? i.e. (noncustodial parent's physical description, name, address and phone of noncustodial Parent's parents, siblings or friends)			
Name of noncustodial Parent's most recent employer and address or phone number of this employer			
Last known date noncustodial Parent was employed:			
If this noncustodial parent has died, enter the date and city and state of death:			
If the noncustodial parent is disabled or incarcerated, describe the disability or where they are incarcerated:			